Amendment No. 2 to SB3528

McNally
Signature of Sponsor

AMEND Senate Bill No. 3528 House Bill No. 3310*

by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, is amended by adding the following as a new part:

Section 71-5-1001. This act shall be known and may be cited as the "Annual Coverage Assessment Act of 2010".

Section 71-5-1002. As used in this part, unless the context otherwise requires:

(1) “Annual coverage assessment" means the annual assessment imposed on covered hospitals as set forth in this part;

(2) "Annual coverage assessment base" is a covered hospital's net patient revenue as shown in its medicare cost report for its fiscal year that ended during calendar year 2008 on file with CMS as of September 30, 2009, subject to the following qualifications:

(A) If a covered hospital's 2008 medicare cost report is for a partial year only, net patient revenue in its medicare cost report shall be annualized to determine such hospital's coverage assessment base;

(B) If a covered hospital was first licensed in 2009 or 2010 and did not replace another hospital, its annual coverage assessment base is the projection for its projected net patient revenue for its first full year of operation as shown in its certificate of need application filed with the health services and development agency;

(C) If a covered hospital was first licensed in 2009 or 2010 and replaced another hospital, the annual coverage assessment base shall be the predecessor hospital's net patient revenue as shown in its medicare

cost report for its fiscal year that ended during calendar year 2008 on file with CMS as of September 30, 2009;

(D) If a covered hospital is not required to file an annual cost report with CMS, then its annual coverage assessment base shall be its net patient revenue as shown in its joint annual report for its fiscal year ending during calendar year 2008, filed with the department of health;

(E) If a hospital's fiscal year 2008 Medicare Cost Report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file dated September 30, 2009, the hospital shall submit a copy of the hospital's 2008 Medicare Cost Report to the Bureau of TennCare in order to allow for the determination of the hospital's net patient revenue for the state fiscal year 2011 assessment;

(3) "Bureau" means the bureau of TennCare;

(4) "CMS" means the federal centers for medicare and medicaid services;

(5) "Controlling person" means a person who, by ownership, contract or otherwise, has the authority to control the business operations of a covered hospital. Indirect or direct ownership of ten percent (10%) or more of a covered hospital shall constitute control;

(6) "Covered hospital" means a hospital licensed under title 33 or title 68, as of the effective date of this act, except an excluded hospital;

(7) "Excluded hospital" means:

(A) A hospital that has been designated by CMS as a critical access hospital;

(B) A mental health hospital owned by the state of Tennessee;

(C) A hospital providing primarily rehabilitative or long term acute care services;

(D) A children's research hospital that does not charge patient for services beyond that reimbursed by third party payors; and

(E) A hospital that is determined by TennCare as eligible to certify public expenditures for the purpose of securing federal medical assistance percentage payments;

(8) "Medicare Cost Report" means CMS-2552-96, the Cost Report for Electronic Filing of Hospitals, as it existed on September 30, 2009; and

(9) "Net patient revenue" means the amount calculated in accordance with generally accepted accounting principles for hospitals that is reported on Worksheet G-3, Column 1, Line 3, of the Medicare Cost Report excluding long term care inpatient ancillary revenues.

Section 71-5-1003.

(a) There is imposed on each covered hospital licensed as of the effective date an annual coverage assessment for Fiscal Year (FY) 2010-2011 as set forth in this part.

(b) The annual coverage assessment imposed by this part shall not be effective and validly imposed until the bureau has provided the Tennessee Hospital Association with written notice that::

(1) It has received a determination from CMS that the assessment is a permissible source of revenue that shall not adversely affect the amount of federal financial participation in the TennCare program; and

(2) It has received approval from CMS for the distribution of additional payments to hospitals to offset unreimbursed TennCare costs as set forth in § 71-5-1005(c)(2).

(c) The general assembly intends that the proceeds of the annual coverage assessment not be used as a justification to reduce or eliminate the state funding to the TennCare program. To this end, the annual coverage

assessment shall not be effective and validly imposed if the coverage or the amount of revenue that is available to the TennCare program to expend in FY 2010-2011 is less than the Governor's FY 2010-2011 recommended budget level unless new federal funding is available to replace state funding during FY 2010-2011.

(d)

(1) The general assembly intends that the proceeds of the annual coverage assessment not be used as justification for any TennCare managed care organization to implement across the board rate reductions to negotiated rates with covered or excluded hospitals or physicians in existence on June 30, 2010. To this end, for those rates in effect on June 30, 2010, the bureau shall include provisions in the managed care organizations' contractor risk agreements that prohibit the managed care organizations from implementing across the board rate reductions to covered or excluded network hospitals or physicians either by category or type of provider. The requirements of the preceding sentence shall also apply to services or settings of care that are ancillary to a covered or excluded hospital or physician's primary license if the physician or covered or excluded hospital, including a wholly owned subsidiary or controlled affiliate of a covered or excluded hospital or hospital system, holds more than a fifty percent (50%) controlling interest in such ancillary services or settings of care, but shall not apply to any other ancillary services or settings of care. For across the board rate reductions to ancillary services or settings of care, the bureau shall include appropriate requirements for notice to providers in the managed care organizations' contractor risk agreements. For purposes of this subsection (d), services or settings of care that are "ancillary" shall mean, but not be limited to, ambulatory surgical facilities, outpatient treatment

clinics or imaging centers, dialysis centers, home health and related services, home infusion therapy services, outpatient rehabilitation or skilled nursing services. For purposes of this subsection (d), "physician" includes a physician licensed under title 63, chapter 6 and chapter 9 and a group practice of physicians that hold a contract with a managed care organization.

(2) This subsection (d) does not preclude good faith negotiations between managed care organizations and covered or excluded hospitals, hospital systems and physicians on an individualized, case-by-case basis, nor is this subsection intended by the general assembly to serve as justification for Tennessee managed care organizations, covered or excluded hospitals, hospital systems or physicians to unreasonably deny any party the ability to enter into such individualized, case-by-case good faith negotiations. Such good faith negotiation necessarily implies mutual cooperation between the negotiating parties and may include, but is not limited to, the right to terminate contractual agreements, the ability to modify negotiated rates, pricing or units of service, the ability to alter payment methodologies, and the ability to enforce existing managed care techniques or implement new managed care techniques.

(3) Notwithstanding the other provisions of this subsection (d), if CMS mandates a TennCare program change or a change is required by federal law that impacts rates and that is required to be implemented by the MCOs in accordance with their contracts, or the coverage assessment becomes invalid, then nothing in this part shall prohibit the managed care organizations from implementing any rate changes as may be mandated by TennCare or federal law.

Section 71-5-1004.

(a) The annual coverage assessment established for this part shall be three and fifty-two hundredths percent (3.52%) of a covered hospital's annual coverage assessment base.

(b) The annual coverage assessment shall be paid in equal quarterly installments, with the first quarterly payment due on the fifteenth day of the first month of the first quarter of the state fiscal year after the bureau has obtained the determination and approval from CMS described in § 71-5-1003(b). Subsequent installments shall be due on the fifteenth day of the first month of the three (3) successive calendar quarters following the calendar quarter in which the first installment is due.

(c) To facilitate collection of the annual coverage assessment, the bureau shall send to each covered hospital at least thirty (30) days in advance of each quarterly payment due date a notice of payment, along with a return form developed by the bureau. Failure of a covered hospital to receive a notice and return form, however, shall not relieve a covered hospital from the obligation of timely payment. The bureau shall also post the return form on its web site.

(d) Failure of a covered hospital to pay a quarterly installment of the annual coverage assessment when due shall result in an imposition of a penalty of five hundred dollars ($500) per day until such installment is paid in full.

(e) If a covered hospital ceases to operate after the effective date of this act, but before the first due date of the annual coverage assessment, its total coverage assessment shall be equal to its annual coverage assessment base multiplied by a fraction, the denominator of which is the number of calendar days from the effective date of this act until the first due date of the coverage assessment, and the numerator of which is the number of days from the effective date of this act until the date the hospital ceases operation.

(f) If a covered hospital ceases to operate after the first due date of the annual coverage assessment, its total coverage assessment shall be equal to its

annual coverage assessment base multiplied by a fraction, the denominator of which is the number of days from the effective date of this act until the date the fourth installment is due, and the numerator of which is the number of days from the effective date of this act until the date the hospital ceased operation.

(g) If a covered hospital ceases operation prior to payment of its full coverage assessment, then the person or persons controlling the hospital as of the date the hospital ceased operation shall be jointly and severally responsible for any remaining assessment installments and unpaid penalties associated with previous late payments.

(h) If a covered hospital fails to pay a quarterly installment of the coverage assessment within thirty (30) days of its due date, the bureau shall report such failure to the department which licenses the covered hospital. Notwithstanding any other law, failure of a covered hospital to pay a quarterly installment of the coverage assessment or any refund required by this part shall be considered a license deficiency and grounds for disciplinary action as set forth in the statutes and rules under which the covered hospital is licensed.

(i) In addition to the action required by subsection (h), the bureau is authorized to file a civil action against a covered hospital and its controlling person or persons to collect delinquent coverage assessment installments, late penalties and refund obligations established by this part. Exclusive jurisdiction for a civil action authorized by this subsection (i) shall be in the chancery court for Davidson County.

(j)

(1) If any federal agency with jurisdiction over this coverage assessment determines that the assessment is not a valid source of revenue or that the methodology for distribution of the additional payments to hospitals from the coverage fee assessment is not valid after an installment has been collected, or if there is a reduction of the

coverage and funding of the TennCare program contrary to § 71-5-1003(c), or if one (1) or more managed care organizations impose across the board rate reductions contrary to § 71-5-1003(d), then:

(A) The bureau shall refund to covered hospitals the installment payment previously collected within forty-five (45) days of such event;

(B) No subsequent installments of the annual coverage assessment shall be due and payable; and

(C) Covered hospitals that have received payments pursuant to § 71-5-1005(c)(2) shall refund to the bureau all such payments within forty-five (45) days of such event.

(2) The bureau will then have authority to make necessary changes to the TennCare budget to account for the loss of the assessment revenue.

(k) A covered hospital, or an association the membership of which includes thirty (30) or more covered hospitals, shall have the right to file a petition for declaratory order pursuant to § 4-5-223 to determine if there has been a failure to satisfy one (1) of the conditions precedent to the valid imposition of the annual coverage assessment.

(l) A covered hospital may not increase charges or add a surcharge based on or as a result of the annual coverage assessment.

(m) Notwithstanding any other provision of this part, if the bureau receives from CMS notification of the determination and approval set forth in subsection (b), and if such determination and approval have retroactive effective dates, then:

(1) Quarterly coverage assessment payments that become due by application of the retroactive determination date from CMS shall be paid to the bureau within thirty (30) days of the bureau notifying the

Tennessee Hospital Association that CMS has issued such determination; and

(2) Quarterly payments to covered hospitals required by § 71-5-1005(c)(2) that become due by application of the retroactive approval date from CMS shall be paid within fifteen (15) days of the bureau notifying the Tennessee Hospital Association that CMS has issued such approval.

Section 71-5-1005.

(a) There is created a segregated account within the state treasury that shall be known as the "maintenance of coverage trust fund." The fund shall not be used to replace any monies otherwise appropriated to the TennCare program by the general assembly or to replace any monies appropriated outside of the TennCare program.

(b) The maintenance of coverage trust fund shall consist of:

(1) All annual coverage assessments received by the bureau; and

(2) Investment earnings credited to the assets of the maintenance of coverage trust fund.

(c) Monies credited or deposited to the maintenance of coverage trust fund together with all federal matching funds shall be available to and used by the bureau only for expenditures in the TennCare program and shall include the following purposes:

(1) Expenditure for benefits and services under the TennCare program that otherwise would have been subject to reduction or elimination from TennCare funding for FY 2010-2011, as follows:

(A) Replacement of one percent (1%) of the seven percent (7%) reduction in covered and excluded hospital and physician reimbursement rates proposed in the Governor’s FY 2010-2011 Recommended Budget;

(B) Maintenance of essential access hospital payments of at least one hundred million dollars ($100,000,000);

(C) Maintenance of payments to critical access hospitals to achieve reimbursement of full cost of benefits provided to TennCare enrollees up to sixteen million dollars ($16,000,000);

(D) Maintenance of payments for the graduate medical education of at least fifty million dollars ($50,000,000);

(E) Maintenance of reimbursement for medicare part A crossover claims at the lesser of one hundred percent (100%) of medicare allowable or the billed amount;

(F) Avoidance of a requirement that TennCare managed care organizations establish maximum reimbursement for providers based on one hundred percent (100%) of medicare;

(G) Avoidance of any coverage limitations relative to the number of hospital inpatient days per year or annual cost of inpatient services for a TennCare enrollee;

(H) Avoidance of any coverage limitations relative to the number of non-emergency outpatient visits per year for a TennCare enrollee;

(I) Expansion of the Standard Spend Down category for TennCare enrollment up to a maximum of seven thousand (7,000) individuals in FY 2010-2011;

(J) Avoidance of any coverage limitations relative to the number of physician office visits per year for a TennCare enrollee;

(K) Avoidance of coverage limitations relative to the number of laboratory and diagnostic imaging encounters per year for a TennCare enrollee;

(L) Maintenance of coverage for occupational therapy, physical therapy and speech therapy services; and

(M) Making medicaid disproportionate share hospital payments at the maximum amount authorized by the federal social security act for FY 2010-2011;

(2)

(A) Solely from the coverage assessment payments received by the bureau, payments to covered hospitals to offset losses incurred in providing services to TennCare enrollees as set forth in this subdivision (c)(2);

(B) Each covered hospital shall be entitled to payments for FY 2010-2011 of a portion of its unreimbursed cost of providing services to TennCare enrollees. Unreimbursed TennCare costs are defined as the excess of cost over TennCare net revenue as reported on the hospital's 2008 joint annual report filed with the department of health. TennCare costs are defined as the product of a facility's cost-to-charge ratio times TennCare charges. The amount of the payment to each covered hospital shall be no less than eighty-three and one hundred fifty-five thousandths percent (83.155%) of unreimbursed TennCare cost for that covered hospital;

(C) The payments required by this subdivision (c)(2) shall be made in four (4) equal installments. Each installment payment shall be made by the third business day of four (4) successive calendar quarters, with the first calendar quarter to be the calendar quarter in which the annual coverage assessment is first levied in accordance with § 71-5-1004. The bureau shall provide to the Tennessee Hospital Association a schedule showing the

quarterly payments to each hospital at least seven (7) days in advance of such payments;

(D) The payments required by this subdivision (c)(2) may be made by the bureau directly to the hospitals or the bureau may transfer the funds to one (1) or more managed care organizations with the direction to make payments to hospitals as required by this subsection. The payments to a hospital pursuant to this subdivision (c)(2) shall not be considered as part of the reimbursement to which a hospital is entitled under its contract with a TennCare managed care organization; and

(3) Refunds to covered hospitals on the basis of payment of annual coverage assessments or penalties to the bureau through error, mistake, or a determination that the annual coverage assessment was validly imposed.

(d) If a hospital closes or changes status from a covered hospital to an excluded hospital and consequently reduces the amount of the assessment such that the amount is no longer sufficient to cover the total cost of the items included in subsection (c), the payments for these items may be adjusted by an amount equal to the shortfall including the federal financial participation. The items to be adjusted and the amounts of the adjustments shall be determined by the bureau in consultation with hospitals.

(e) The bureau shall modify the contracts with TennCare managed care organizations and otherwise take action necessary to assure the use and application of the assets of the maintenance of coverage trust fund, as described in subsection (c).

(f) The bureau shall submit requests to CMS to modify the medicaid state plan, the contractor risk agreements or the TennCare II Section 1115 demonstration project as necessary to implement the requirements of this part

without first submitting the proposed modifications to the select oversight committee on TennCare as required by § 3-15-508.

(g) At quarterly intervals beginning September 1, 2010, the bureau shall submit a report to the select oversight committee on TennCare, to the finance ways and means committees of the senate and house of representatives, to the general welfare, health and human resources committee of the senate and to the health and human resource committee of the house of representatives, which report shall include:

(1) The status if applicable of the determination and approval by CMS set forth in § 71-5-1003(b) of the annual coverage assessment;

(2) The balance of funds in the maintenance of coverage trust fund; and

(3) The extent of which the maintenance of coverage trust fund has been used to carry out this part.

(h) No part of the maintenance of coverage trust fund shall be diverted to the general fund or used for any purpose other than set forth in this part.

Section 71-5-1006. This act shall expire on June 30, 2011; provided, however, the following rights and obligations shall survive expiration of this act:

(1) The authority of the bureau to impose late payment penalties and to collect unpaid annual coverage assessments and required refunds;

(2) The rights of a covered hospital or an association of covered hospitals to file a petition for declaratory order to determine whether the annual coverage assessment has been validly imposed; and

(3) The obligation of the bureau to use and apply the assets of the maintenance coverage trust fund.

SECTION 2. This act shall take effect upon becoming law, the public welfare requiring it.